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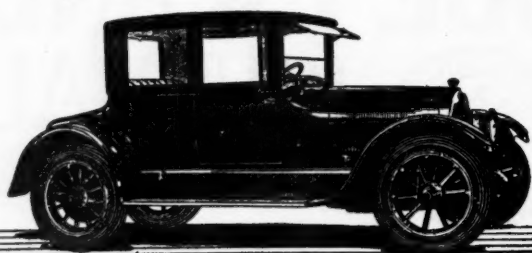
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ORIGINAL ARTICLES

DIAGNOSIS AND TREATMENT OF GALL BLADDER DISEASE.*

By CHARLES O. COOKE, A. M., M. D.,
Providence, R. I.

In choosing a subject for the meeting this afternoon, it seemed to me that we might profitably spend the time in considering the history, symptoms, diagnosis, and briefly, the treatment of gall bladder disease. Gall bladder disease in this paper is defined as inflammation of the gall bladder with or without the presence of gall stones. Our early instruction in gall bladder disease, cholecystitis, was really based on the clinical picture of the complications of the disease; for example, when a stone became impacted in the cystic or common duct or when jaundice intervened.

In Osler's "Practice of Medicine" not many years ago, we find the following statement: "In a majority of the cases, gall-stones cause no symptoms. The gall-bladder will tolerate the presence of large numbers (of gall stones) for an indefinite period of time and post-mortem examinations show that they are present in twenty-five per cent of all women over 60 years of age." (Naunyn.) This statement accepted at the time by all of us, must now be modified, yes, contradicted. We now know that gall stones in the gall bladder do produce symptoms. We know that these patients complain of so called indigestion, belching of gas, distress after meals, attacks of colicky pains, chilly feelings, and so on. These are the cases variously diagnosed as indigestion, gastralgia, gastritis, intestinal indigestion, colitis, and so on. They drift along for years until suddenly a stone becomes lodged in the cystic or common duct with all the train of symptoms of gall stone colic, chills, fever, and possibly jaundice. Then the diagnosis is readily made and the patient is critically ill. An

operation must be performed to save the patient's life. The operation at this stage is often difficult and the mortality is easily 10-45 per cent. If we can recognize these cases while the disease is confined to the gall bladder the operation is much easier and the mortality is low.

In considering gall bladder disease, we recognize two distinct types: cholecystitis with stones, cholecystitis without stones.

ETIOLOGY. Cholecystitis is of bacterial origin. Typhoid fever is undoubtedly a precursor of the disease. It is believed that the gall bladder becomes infected during the course of the disease, in many instances with the later formation of stones.

Pregnancy is a very important precursor of cholecystitis. In many of my cases, I have been able to trace the beginning of symptoms to a stormy puerperal period, where infection probably took place, either at full term or following a miscarriage.

Focal infections undoubtedly play a part. It is believed by Rosenow of the Mayo Clinic and others that streptococci from diseased foci under tension, for example, diseased tonsils, abscesses at roots of teeth, diseased sinuses, etc., find their way into the circulation and attack the wall of the gall bladder, causing cholecystitis with or without stones. This theory has been supported by definite laboratory experiments.

Rosenow took the diseased gall bladders removed at operation and proceeded as follows. He first cauterized the mucous membrane of the gall bladders with a red-hot iron. This killed all germs on the surface. He then ground up these gall bladders, mixed them up in sterile salt solution and grew cultures. From these cultures he isolated a streptococcus. These streptococci injected into dogs produced cholecystitis and in many cases, gall stones were found. The streptococci isolated from the human cases of diseased gall bladders showed an elective action for the gall bladder soil in

*Read before the Rhode Island Medical Society, September 2, 1920.

- dogs. It proves the presence of the infection and bacteria in the gall bladder wall, controverting the old idea that the infection was on the surface. It very clearly shows the necessity of removing the gall bladder rather than depending on short time drainage of the structure to cure the disease.

SYMPTOMS. Gall bladder disease is far more common in women than in men. These women are usually fat. The early symptoms are all referred to the stomach. The patient complains of a fullness in the epigastrium and of distress after eating. She gets relief by loosening her corsets or by making pressure over the stomach, i. e., epigastrium. Further relief comes from belching of gas. She may complain of colicky pains and of chilly feelings. There may or may not be tenderness over the gall bladder area. Given these symptoms in a woman who has borne children and is between 30 and 50 years of age, a diagnosis of cholecystitis and probable gall stones can safely be made. An old saying of Deaver's in regard to the symptoms of cholecystitis is "fair, fat and forty and belching of gas in a woman." I would like at this point to report a case of cholecystitis with stones proved at operation in which the stones were confined to the gall bladder.

CASE OF M. T., age 54, cholecystitis, cholelithias. March 12, 1919. P. H. Previous history of pain in stomach, pain around the heart, indigestion. Several previous diagnoses of cardiac trouble, indigestion and pelvic trouble. Ten days ago began to have abdominal pain beginning in right upper quadrant and passing to epigastrium. No relation to meals. Vomited bile. March 13, X-ray plates taken of gall bladder region show nothing definitely abnormal. In this case, it was thought better to wait until the acute symptoms subsided. Consequently, patient was kept in bed until March 31, 1919, when all symptoms had subsided. In the interval, pain was controlled by morphine, sodium bromide and the ice-bag.

Leucocyte count: March 14, 15,800; March 20, 23,000; March 23, 7,400.

March 31, 1919, cholecystectomy with difficulty, owing to the fat abdomen. Gall bladder full of stones, ducts free.

Convalescence was slow owing to infection of wound and later to development of tonsillitis.

Patient has been entirely relieved of symptoms and says she has not felt so well in years.

Such is the early history of cholecystitis with or without stones. Later the stones may leave the gall bladder and become impacted in the bile ducts. Immediately the picture changes and the symptoms become violent. The patient goes through an attack of gall stone colic. The attack sets in abruptly with agonizing pain in the right hypochondriac region, which usually radiates to the right shoulder or is very intense in the epigastric and lower thoracic regions. It is often associated with chills and fever and temperature from 102 to 103 degrees. The pain is usually intense and the patient rolls around in agony. There is vomiting, profuse sweating, and great depression of the circulation. The patient is only relieved by morphine. If the stone becomes lodged in the cystic duct, hydrops of the gall bladder occurs and an enlarged, palpable gall bladder is felt. The gall bladder at this stage contains a mixture of bile and mucus. Later on the bile disappears and the gall bladder contains pure mucus. I have recently operated upon such a case.

CASE OF E. S., age 59, married. Acute hydrops of the gall bladder, chronic cholecystitis, cholelithias.

COMPLAINT. August 12, 1920. Sharp, stabbing pain beginning over the iliac crest, radiating up to right costal margin and over to pit of stomach. Twenty-five years duration.

PAST HISTORY. First attack occurred when younger son was about five months old; similar attacks recurring during the last twenty-five years more severe in character. Patient was first told that her trouble was indigestion and later on, malaria. Still later on, she was told that in some way, she had strained the sciatic nerve in reaching, causing pressure of gas in the stomach. The time between attacks was from three months to two years. The only relief from pain was from hypodermic injections of morphine. The attacks came on with severe pain in the right side of the abdomen extending across the back, stomach, and down to the right hip. She usually vomited considerably which relieved the pain somewhat. Patient had no other organic trouble as far as she knew except the disturbed stomach condition during the gall bladder attacks and difficulty in breathing which

she felt was caused by gas pressure on the heart.

PRESENT ILLNESS. One week ago, patient began to have sharp, severe pains in right side and back. Vomited considerably, sour bitter taste. No jaundice. Has had similar attacks without jaundice for past twenty-five years.

OPERATION. August 13, 1920. Appendectomy, cholecystectomy. Five (5) inch gall bladder incision. Appendix normal. Removed in usual manner. Acute hydrops of the gall bladder which was tensely distended. Gall bladder aspirated and about two ounces of mucus removed. Gall bladder wall very friable, impossible to clamp it. Gall bladder dissected out with finger from below, leaving raw surface of gall bladder bed. Cystic duct tied and cut. Iodoform gauze drain in gall bladder bed and one cigarette drain to stump of cystic duct. Incision closed in layers above and below drain. Gall bladder was $\frac{3}{8}$ inch thick, œdematous and friable, and contained four large stones, size and shape of ordinary dice, one stone being wedged tightly in cystic duct.

In certain cases, the gall bladder becomes filled with pus, producing an empyema of the gall bladder.

The gall bladder may become gangrenous and even perforate. There is usually in this type of gall bladder trouble, a rather active peritonitis of the upper abdomen. Adhesions are rapidly formed to wall off the infection and an abscess may develop. In other cases the infection may spread and a general peritonitis develop.

If the stone become not impacted in the cystic duct but continues on through the common duct, jaundice is very apt to occur, due to obstruction of the common bile duct and also, to swelling of the duct due to infection. The pancreas often becomes infected and a chronic pancreatitis set up.

The stone may become lodged in the common or hepatic ducts and stay there indefinitely. The stone rarely completely plugs the common duct, but acts as a ball valve, allowing bile to pass off and on. These cases are the ones that present the picture of intermittent attacks of pain, fever, chills and jaundice. Infection of the duct takes place and even the small bile ducts in the liver may become infected.

The stone may become lodged at the duodenal orifice of the common duct. I saw such a case in consultation. In this case, the patient had been jaundiced for five weeks, refusing operative treatment. At operation, a single stone was found impacted at the entrance of the common duct into the duodenum near the ampulla of Vater. The bile ducts above were greatly dilated. The common duct was opened and the stone removed with considerable difficulty, so tightly was the stone impacted. There was no bile in any of the ducts or gall bladder. The bladder had temporarily ceased functioning. After operation a rubber catheter was stitched in the common duct for drainage. There was no drainage of bile from the catheter for five days. Gradually the liver began to functionate and free drainage of bile took place and the patient recovered after a stormy convalescence.

Just a few words about cholecystitis without stones. There is a type of cholecystitis which seldom forms stones, the so called strawberry gall bladder. It is so named because the raised white spots on the mucous surface give it the appearance of a strawberry. These spots may occasionally be seen through the wall of the gall bladder. This condition is frequently accompanied by chronic pancreatitis with or without jaundice. Removal of the gall bladder cures the pancreatitis.

The regional lymphatics at the junction of the cystic and common ducts are always enlarged in cholecystitis. In doubtful cases, these glands should be sought for before removing a doubtful gall bladder.

Malignancy of the gall bladder and ducts occasionally occurs. It is so rare that I have not considered it in this brief paper.

DIAGNOSIS. In examining a patient for suspected gall bladder disease, we must not neglect the routine physical examination. This is of double value. It not only often saves us from a mistake and the patient from a needless operation, but it also gives us valuable information as to the general condition of the patient and also gives us a chance to estimate the surgical risk.

I recall one patient whom I anesthetized for another surgeon in which failure to examine the heart led to a needless exploratory operation on a normal gall bladder.

Many other cases I have seen operated upon needlessly when a complete physical examination would have shown absent knee jerks and absent pupillary reflexes, when the true diagnosis was *tabes dorsalis* and not gall bladder disease and the pain was the girdle pain of *tabes* and not gall bladder pain.

We all know and I wish to emphasize that more mistakes are due to carelessness in examination than to ignorance.

A complete physical examination should be made. The heart, lungs, and abdomen should be carefully gone over. The blood pressure should be taken in every case. The urine should be examined.

A case I operated upon two years ago in which the diagnosis was fully established before operation, showed a marked mitral lesion, an elevated blood pressure, and albumen and casts in the urine. The patient was a young woman 35 years of age, the wife of a physician. The kidney function was 30 per cent. The question arose as to the operative risk. An electrocardiogram was taken and the opinion expressed by Dr. Fulton that the heart was in good condition and would stand the strain. The question of nephritis and diminished kidney function was discussed with Dr. De Wolf who believed that the kidneys would stand the strain. The gall stone attacks were increasing in severity requiring morphine injections. It was also felt that possibly the gall bladder was a focus of infection to the kidneys and that the removal of the gall bladder might help the kidney condition. After weighing all the evidence it was decided to proceed with the operation. The patient was given ether and the appendix and gall bladder were removed. The gall bladder contained sixty large sized gall stones. The patient made an excellent recovery and as far as I know has been entirely relieved from symptoms since. The present condition of the heart and kidney I do not know.

The reflexes should be carefully gone over. In cases like the one just mentioned the kidney function should be estimated.

The white count is of some value in the acute cases. It will show whether or not acute infection is present and the estimation of the polynuclear cells will give us a clue to the patient's resistance.

X-RAY. The X-ray is of some value in obscure cases. In one of my cases, an X-ray examination revealed the outline of a diseased gall bladder, which when removed at operation, was found to be white and thickened and to contain about fourteen gall stones with spicules.

It is stated by Dr. Gerber that a normal gall bladder never shows in the X-ray plate.

As to the diagnosis of gall stones by the X-ray, my experience has been that the pictures usually fail to show the stones. In a very few cases I have seen shadows indicating gall stones, but in most of my cases the X-ray report has been negative for stones.

ABDOMEN. The abdomen should be carefully examined first by inspection. Inspection will sometimes show the presence of a tumor or swelling. The patient should be instructed to take a long breath. Occasionally the edge of the liver can be observed to descend with inspiration. If a tumor be present, its exact location, shape, and size should be noted. A distended gall bladder is gourd shaped.

After a careful inspection, the abdomen should be carefully palpated. Any rigidity of the muscles should be noted, any masses seen or felt should be carefully outlined, during both inspiration and expiration. A mass in the upper abdomen may be liver, kidney, gall bladder, stomach, intestinal tumor, and in rare cases, a fecal impaction. How shall we differentiate? If the mass be liver, it can usually be demonstrated to be continuous with the liver especially by percussion. If the mass be kidney, it can be bimanually palpated with the patient on the left side. There is as you remember tympany on percussion over a kidney because the colon lies over the kidney. Conversely, if the mass be gall bladder, it is dull on percussion. A distended gall bladder may often be moved in the arc of a circle, the attachment at the liver being a fixed point. Intestinal and stomach-tumors are usually ruled out by their location and in these cases the bismuth meal and X-ray examination give information which can be obtained in no other way. If no mass be present the abdominal examination may show nothing abnormal. Usually and almost always in the attacks, there will be localized tenderness in the gall bladder region.

After palpation, careful percussion of the abdomen should be done. This is useful in determining the size of the liver, the presence or absence of faecal impactions, the outlining of masses or tumors previously noted. In acute cases, it is useful in determining the presence or absence of free fluid in the belly. This is very important in the acute cases. Free fluid in the belly is an indication (1) of free bile escaping from a ruptured gall bladder (2) of spreading diffuse peritonitis. To determine free fluid the abdomen is percussed until dullness is reached in the flanks and the line marked with a pencil. The patient is then turned on his side and any change in the line of dullness is noted.

TREATMENT. Removal of the gall bladder is the operation of choice for cholecystitis and gall stones. We formerly believed that drainage of the gall bladder was sufficient. That this treatment was faulty was shown by the rapid recurrence of the same symptoms that the patient suffered before the operation. After a cholecystostomy, or drainage operation, the patient is relieved for a time and then begins to experience his former symptoms. The reason for this is that we have left an infected gall bladder. Such a case I wish to report at this time.

CASE OF F. B., age 24, married, cholecystitis with gall stones. Nov. 16, 1909. Nine days ago woke up in night with pain in epigastrium, radiating to the back. Sharp cutting pain for one and one half hours required morphine to relieve. Vomited several times. Constant ache for nine days. Attacks of severe pain every day—today worst of all. Urine dark colored.

P. H. Eight years ago had indigestion, troubled a great deal with gas on the stomach. Had a great deal of distress until relieved by eructations of gas. Used to vomit almost everything eaten. Three years ago had an attack with pain in epigastrium and vomiting. Has had slight indigestion at times since.

P. E. Patient slightly jaundiced. Rigidity over upper abdomen, marked tenderness over whole upper abdomen, most marked in epigastrium and to right of median line. No masses, no dullness in flanks Nov. 19, 1909. Cholecystostomy for gall stones, appendectomy. Three inch right rectus incision. Gall bladder full of small stones. Gall bladder much thickened and reddened and 25 or 30 small irregularly round

stones removed with scoop. Several small stones milked up from common duct (?) and removed. Rubber tube in gall bladder. Appendix removed Nov. 26. Tube removed. Dec. 8. Discharged cured.

Readmitted on November 13, 1918. Diagnosis of acute colitis, age 33.

COMPLAINT. Pain in right upper quadrant radiating to the pit of the stomach. Has had no symptoms until one year ago when, during pregnancy at this time, vomited constantly just after eating. Four months ago, vomited constantly for five days and five nights. Vomitus was brownish green. Bowels constipated. Pain radiating from stomach and right side to shoulder blade. Last menstruation Nov. 17, 1917. Patient in bed most of time during past year; felt constant pain and weakness.

P. H. One year ago developed pain in right side and pit of stomach.

P. E. Negative.

X-ray examination, bismuth series. The plates show evidence of slight adhesions in the first portion of the duodenum to the region of the gall bladder. No definite evidence of stone could be seen on the plates. The remainder of the examination shows evidence of a distended prolapsed cæcum with considerable amount of cæcal stasis. Discharged improved Nov. 19, 1918.

Dec. 26, 1918. Admitted for third time. One year ago began to have a pulling feeling from under right arm down toward old incision. Three months ago began to have sharp, crushing pains starting in right hypochondrium and going down to epigastrium through to back. Severe attacks of pain every day for a while. Becomes distended with gas during attacks, vomits with most attacks. Was slightly jaundiced during September and November.

Jan. 2, 1919. Cholecystectomy. Five inch right rectus incision from epigastrium to just below umbilicus. Right lobe of liver adherent to old scar. Gall bladder could not be seen. Edge of liver freed from peritoneum. Gall bladder densely adherent to liver above and pylorus and duodenum below. Adhesion cut away, gall bladder freed and seized with curved clamp. Gall bladder 6 inches long, very much thickened, pelvis of gall bladder contained

fifteen small stones. Discharged cured, January 25, 1919.

In any operation for gall bladder disease the common and hepatic ducts must be carefully examined and any stones present in those ducts should be removed. In such cases, the common duct should be drained by a rubber tube or soft rubber catheter. In cases of gall bladder disease and coexistent chronic pancreatitis with jaundice, a cholecystenterostomy should be performed. The gall bladder may be anastomosed to the duodenum, or even to the stomach or colon where the first named procedure is difficult.

In cholecystitis with chronic pancreatitis, without jaundice, cholecystectomy is the operation of choice. It is not necessary to drain the common duct in cases without jaundice. The removal of the gall bladder, thereby removing the focus of infection, cures the chronic pancreatitis.

In performing an operation on the gall bladder, the entire abdomen should be explored and any other pathological condition noted and corrected at the time or later by a second operation.

In a well placed incision it is easy to remove the appendix through the same incision and this should be done in every case.

In experienced hands, the operative risk is the same for cholecystostomy or cholecystectomy.

In exceptional cases, where acute infection is present outside the gall bladder, it may be desirable to drain the gall bladder and peritoneum to tide the patient over the dangerous period and then later go in and remove the gall bladder.

Recurrence of symptoms after operation are most common after drainage of the gall bladder where a diseased gall bladder is left in situ.

In other cases, stones are overlooked in the gall bladder or in the cystic or common ducts.

Recurrence of symptoms may be due to chronic pancreatitis. This is more common after cholecystostomy than after cholecystectomy.

In rare cases, adhesions may cause a recurrence of symptoms, but the Mayos believe that this is rather uncommon after cholecystectomy.

In a series of 2027 operations at the Mayo clinic, there were 219 secondary operations,—10.8 per cent.

Eighty per cent of these were for removal of the gall bladder,—120 cases. In 4 cases, secondary cholecystostomy was done owing to the poor condition of the patients. Two of these patients died.

In 109 of 219 patients, calculi were found either in the gall bladder, the ducts or both. One hundred and fifty-three patients had cholecystitis, in some instances, associated with stones. Adhesions were definitely noted in 148 cases and in 41 there was a definite pancreatitis. Either a mucous or biliary fistula was present in 37 cases. Seventeen of the 219 cases were definitely jaundiced. At the first operation stones were found in 154 of the 219 cases, in the gall bladder in 140, in the ducts 9, and in the gall bladder and ducts 5. Stones were found at the second operation in 109 cases. In 59 cases in the gall bladder, in 4 in the gall bladder and ducts, and in 41, in the ducts.

CONCLUSIONS. (1) Removal of the gall bladder is the operation of choice. It reduces the risk of later trouble and ordinarily is to be preferred to cholecystostomy for drainage.

(2) Infection in the gall bladder, liver, or ducts is the most frequent cause of secondary trouble and may recur many years after the primary operation.

(3) Recurrence of stones is more frequent in the gall bladder than in any other portion of the biliary tract. The common duct is next in report of frequency.

(4) In a small percentage of cases, stones will be overlooked in the common duct, in other cases, the stones reform in the duct.

DISCUSSION OF DR. COOKE'S PAPER.

DR. JOHN B. MCKENNA, East Providence, R. I., emphasized the point that chronic indigestion should be regarded as suspicious of gall bladder disease.

DR. JACOB S. KELLEY, Providence, R. I., spoke of the importance of the X-ray examination of the entire gastro-intestinal tract, if necessary, to determine the site of disease, which might lie outside the gall bladder itself.

DR. GEORGE W. GARDNER, Providence, R. I., emphasized the point that gall stones are the result of previous infection of the gall bladder and the importance of early diagnosis in these cases.

The removal of the gall bladder is usually of more value than drainage. but that in many cases it was necessary to drain the gall bladder rather than attempt to remove it.

DR. FREDERICK N. BROWN, Providence, R. I., reported a case of gall stones which had once come under his observation and had received various forms of treatment. A cure had eventually resulted following a course of osteopathic treatments.

DR. ISAAC GERBER, Providence, R. I., referred to the X-ray examination as intended to determine the presence of some pathological condition of the gall bladder or its vicinity rather than to determine the presence or absence of gall stones. The presence or absence of gall stones is not the important factor. Among conditions which may cause symptoms of gall bladder disease and which can be differentiated by accurate X-ray examination are the following: (1) gall stones; (2) pathological gall bladder (strawberry type); (3) pressure defects such as concave impressions of the duodenum seen with the opaque meal; (4) adhesions of the gall bladder to the hepatic colon or liver; (5) local dilatation of the end of the pancreatic duct in cases of pancreatic disease.

DR. CHARLES O. COOKE, Providence, R. I., closing, said that he had not intended to underestimate the value of the X-ray in the diagnosis of gall bladder disease, but thought that dependence should be placed upon the X-ray only in obscure cases.

CASE REPORT

SALIVARY CALCULUS.

By JAMES W. LEECH, M. D.,
Providence, R. I.

Mrs. C. L., aet. 52, was seen June 12, 1920, complaining of swelling and soreness in the right neck of a few days duration.

PREVIOUS HISTORY: She stated that in January, 1919, there developed a swelling below the angle of the right jaw, tender, red and causing painful mastication. On advice of her physician in a neighboring State, all her teeth were extracted, followed by vaccine injections—nature not known—and the swelling subsided in two to three weeks.

PRESENT ILLNESS: On June 4, 1920, swelling below and anterior to the angle of the jaw appeared again, made more painful and larger by attempts to eat. Palpation externally and through the floor of the mouth demonstrated the swelling to be the right submaxillary salivary gland. The outlet of Wharton's duct was slightly more prominent than its fellow.

With Nos. 1 and 2 lachrimal probes the opening was enlarged and a eustachian whale-bone bougee introduced the entire length of the duct into the gland where a grating sensation made certain the presence of a salivary calculus. The duct opening was enlarged by slitting with a Graefe knife and the smallest size Hartman middle ear curette introduced full length. Although this reached the stone, it was impossible to deliver it through the duct and therefore with the curette still in place the duct was opened directly over the stone which was delivered through this wound.

The calculus was yellowish in color, chalky in consistency and about the size and shape of an uncooked pea-bean.

The subsequent history was uneventful, a flow of pus lasting for two or three days with healing complete and entire subsidence of glandular swelling and soreness in one week.

[This case report should point a moral to those physicians who see in supposedly diseased teeth the root of all physical ills and pains.—Ed.]

ANALYSIS OF WASSERMANN REACTIONS.*

Made in Butler Hospital Between June 1, 1919 and Aug. 1, 1920.

HARVEY B. SANBORN, M.D.,
Providence, R. I.

The Wassermann test is an accepted aid in the diagnosis of syphilis of the central nervous system and will, I believe, remain so. There is no question but that when done by properly trained workers in a modern laboratory, it is of great positive value: the only question is as to how we must interpret the partial reactions, i. e., a one to four plus with cholesterin and a negative with acetone or an antigen of like degree of sensitiveness, or a negative reaction along with positive clinical signs.

*Read before the Rhode Island Medical Society, September 2, 1920.

A plus reaction in any degree with acetone or a similar antigen, except in the presence of a very few unusual conditions, means syphilis almost always. Still in a doubtful case it is well to repeat or get the result of another laboratory. A negative result on the blood does not rule out syphilis of the nervous system by any means. In suspicious cases a further test of the spinal fluid should be made as we may obtain a positive result on the spinal fluid when the blood is negative and this means syphilis of the nervous system. Along with this we generally find some increase in cell count and globulin but a positive result of any one of these three tests on the spinal fluid in the absence of meningitis or polio-encephalo-myelitis, points toward syphilis.

In those cases where the result is positive with cholesterin but negative with acetone, if not the result of anti-syphilitic treatment, I think we should repeat the test a little later and certainly have all the available tests on the spinal fluid performed, meanwhile reserving our decision. A provocative dose of arsphenamin in a case with a partial or negative reaction will sometimes cause a positive result afterwards.

Dr. Ruggles and I have gone over the laboratory findings made in this laboratory from June 1, 1919 to August 1, 1920, the work of Dr. Carl A. Sawyer, and checked them up with our clinical findings. The result, we think, is sufficiently interesting to present:

One hundred and sixty-four patients have had Wassermann tests on blood or on both blood and spinal fluid.

There are 117 of these in which blood alone was examined and found negative with both antigens; and as there was no clinical evidence or history of syphilis, lumbar puncture was not done.

In 21 cases both blood and spinal fluid were examined and found negative with both antigens.

In two of these cases lumbar puncture was done to establish the diagnosis of endemic encephalitis.

In the other 19 cases the spinal fluid was examined because of a history of previous ven-

ereal infection; evidence of organic disease,—e. g., arteriosclerosis, brain tumor, or some alteration in the reflexes; or to clear up the diagnosis where the mental picture was unclear.

In all the cases of these first two groups, continued clinical observation failed to reveal any evidence of syphilis.

There were 17 cases which clinically were undoubted cases of paresis or neuro-syphilis, and in which the laboratory findings were as follows:—

Twelve showed both blood and spinal fluid positive with both antigens, and also showed an increase in cells in spinal fluid; three showed a positive spinal fluid but a negative blood, and of these three all but one had had previous treatment. Clinically, two of these are cases of paresis; and one of them a case of tabes with mental symptoms; two cases showed a positive blood with a negative spinal fluid, and of these one had had previous treatment.

There are left nine cases, eight of whom showed at some time a positive blood reaction with the cholesterin antigen but not with acetone. The other one of these nine, showed a one plus reaction with cholesterin antigen on the spinal fluid but a negative blood.

Of these nine cases, three were known to have had syphilis and to have received intensive treatment for this. Two others had a history indicating a previous syphilis. The remaining four cases will have to be classed as doubtful cases. We have in them no direct evidence of syphilis; either from the history or from clinical findings. One of these cases has been lost sight of; in the other three, repeated laboratory examinations and clinical observations will probably clear up the question of the presence or absence of syphilis.

In our opinion, the laboratory findings follow very closely the clinical observations. A very small percent of cases show a weakly positive reaction with cholesterin, and in our experience these are either cases which have been treated or ones in which the diagnosis can be cleared up by the repeated examination of blood and spinal fluid.

THE RHODE ISLAND MEDICAL JOURNAL

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EDITORIALS

AN EDITOR'S DREAM.

No one who reads much of contemporary medical literature will be disposed to deny that it is, on the whole, interesting and instructive. But having said this, one cannot but remark that it lacks at least one of the virtues that characterized the writings of the older physicians, we mean the clinical spirit and flavor. Why is it that article after article appears in our journals and yet out of so great a number so few treat of the helpful and common things that we medical men

most desire to know? Perhaps it is that writers in their search for the rare or the unusual are under a misconception as to what constitutes a valuable medical paper. We are supplied with enough and more than enough of imposing tables of statistics which, as Professor Karl Pearson has shown, have the appearance of science without its substance. For who but the veriest tyro would claim for statistical enumerations, as usually compiled, more than a very questionable value? We read positive statements about the utility of this drug or that in such and such a disease, but when we look more closely

into the premises of the writer's conclusions we discover frail foundations and not a little confusion of thought. Again, for example, vaccines are enthusiastically used and their virtues generally extolled with no apparent sense of their limitations and dangers. Blood-pressure readings are taken and if deemed excessive, we are forthwith assured that the patient's symptoms are explained; and this, too, in the face of the fact that high blood-pressure of itself, does and can explain very little. And so with all our printing presses we are bewildered in the midst of an accumulation of facts and of doctors who disagree.

Some day in the future, the not distant future, let us hope, the Editor of the RHODE ISLAND MEDICAL JOURNAL will receive in his mail an uncommon kind of article. As he reads it, a pleasant glow of satisfaction will suffuse his countenance and he will experience a quite unmistakable feeling of exhilaration. The author will submit it with an altogether too modest expression of reticence, the reason of this being that his contribution will seem to him so unlike the usual run of papers. And so will it be, for immediately he begins its perusal the Editor will observe that from his new contributor, a country practitioner perhaps, he is getting a discussion not of words but of things. The author has followed Lord Bacon's advice to learn from the things and not from the books about the things.

Here, indeed, is a man who has patiently studied human beings during the complex mutations of disease, who knows how to distinguish essential from merely contingent happenings, who has for long watched the effects and the interplay of regimen and remedies, and who has had leisure at night to reflect upon the experiences of the day. Leisure to reflect! What a difference that makes in his writing, giving directness to his descriptions, clearness to his statements, balance to his judgments.

Delighted thus far, the Editor is somewhat surprised to notice the complete absence of the customary rhetorical flowers plucked from German, French and other gardens. But the explanation soon appears. The author has no need of them. Like Duchenne of Boulogne

he is too busy setting down what he has himself seen in hospital, in office, and at the bedside to encumber his pages with the discussion of other men's thoughts. Moreover, this writer thinks concretely and allows himself no high imaginings, for being of a practical turn of mind he will not permit himself to be misled by such airy subtleties as "disease entities," "morbid species," and "environmental influences." He describes few cases, but does so with great accuracy and a nice precision, because as he says, he is convinced that one case well studied over a considerable period of time is worth a score superficially observed for a mere fraction of their course. Finally, the author has something to say about treatment, since even in these days of diagnosis he is old-fashioned enough to believe that treatment still interests the patient. He tells what happened to those to whom he gave no treatment and how things turned out with those patients whom he treated this way or that.

Having finished his reading, the Editor will muse whether outside of a dream (for he has been dreaming all the while) he will ever receive this new and simply delightful kind of paper. He knows full well that among his readers are some who can send it to him, and may he venture to hope that before long his dream may take on form and substance?

THE PRE-SCHOOL CHILD.

The present era is without question the era of the child. Previous to 1915 there were but two divisions of child Welfare in all the States, whereas at the present there are 34 such divisions. More and more are the authorities realizing that the best results in prevention come through child conservation. There is still one period of child life that has not received the proper amount of attention—namely, the pre-school period. This period marks the transition of the child from its helplessness as an infant, to its assumption of responsibility in its school work. The prenatal clinics and the child welfare stations afford plenty of opportunity for the mother to receive advice about the development of her baby, but most stations do not attempt to follow the child after its second birthday.

Also on the other side, the child in school is under the supervision of medical and dental inspectors, school nurses and recently in some communities is given the opportunity to have special care in the malnutrition classes. Certain it is that this period from two to six years is a most important one in the development of the child and it is hoped that in the future the same consideration and the same opportunities will be given to the pre-school child as is now given to the babies and to the child in school.

THE FISKE FUND.

The Society is remiss in fulfilling its obligations to the Caleb Fiske Fund and the noticeable absence of its members from the list of contestants is partly due to ignorance of the provisions of the deed of gift.

The records of the Trustees of the Fiske Fund are not available, but for a number of years there have been but one or two members of the Rhode Island Medical Society who have presented essays in competition for the prize.

It is not to our credit and it was not the intent of the donor that his prize should so frequently go to non-residents of Rhode Island. In the deed of trust it says "the Trustees shall cause these proceedings in the premises to be recorded in a book or books from year to year and deposited in the archives or cabinet of said Society, for safe keeping, inserting thereon the annual amount of said fund and the addition, if any, made thereto, the subject or subjects proposed for investigation, the amount of premiums offered, the names and places of abode of persons to whom premiums are awarded with such other facts and remarks relative to the application of such dividends as they may judge expedient and the proceedings or such parts thereof, as shall be audibly read before said Society at the annual meeting shall also be subject to the inspection of any member of the Society." This provision has not been carried out and without prejudice to the appointed secretary and treasurer of the Trustees, who has so faithfully attended to all of the details of the management of the Fund for many years, should be remedied.

The records of the Trustees, the statement of the treasurer of the Fund, its annual expenditures and present value should be made at each annual meeting. The Trustees should by record vote, re-elect its treasurer each year, that in event of the death or incapacity of the incumbent there may be no difficulty in transferring the Funds to his successor. There should moreover, be an audit of the books annually and especially in view of the definite provision of the donor should the records be kept in the library of the Society and available to any member of the Society, who may be desirous of entering into competition for the annual prize.

The Trustees of the Fiske Fund are responsible for the proper performance of the Society in fulfilling its obligations. The matter should receive prompt attention.

SOCIETY MEETINGS

PROVIDENCE MEDICAL ASSOCIATION.

June 7, 1920.

The regular monthly meeting of the Providence Medical Association was called to order in the Medical Library by President D. L. Richardson on June 7, 1920, at 8:50 p. m.

The records of the previous meeting were read and approved.

A letter of appreciation from Lydia V. Mitchell for the memorial on the death of Dr. J. W. Mitchell was read.

The first paper of the evening, "The Treatment of Syphilis", was read by Dr. Hilary J. Connor, which was a resume of the result of the work done in the Syphilis Clinic at the Providence City Hospital.

Following Dr. Connor's paper, Dr. Walter M. Burnett of New York presented a motion picture series depicting the symptoms, laboratory technique and treatment of syphilis.

The discussion was opened by Dr. C. D. Sawyer and continued by Drs. Henry McCusker, J. E. Kerney, A. Ruggles, C. A. McDonald, G. Swarts, C. O. Cooke, and C. H. Leonard. Dr. Connor and Dr. Burnett closed their discussions.

There being no further business the meeting was adjourned at 10:25 p. m. on a motion by Dr. Burge.

Attendance: 64 members and 12 guests.
Collation was served.

Respectfully submitted,

RAYMOND G. BUGBEE, M. D.,
Secretary.

WASHINGTON DISTRICT MEDICAL SOCIETY.

The quarterly meeting was held at the Colonial Club, Westerly, R. I., October 14, 1920, at 11 a. m. Paper: "Diseases of Stomach," by D. Frank Gray, M. D., of Providence.

W. A. HILLARD, M. D., *Secretary.*

HOSPITALS

RHODE ISLAND HOSPITAL.

The regular quarterly meeting of the Rhode Island Hospital Staff Association was held at the hospital, October 11, 1920, at 8:45 p. m. Routine business was transacted.

NORMAN C. BAKER, M. D., *Secretary.*

MEMORIAL HOSPITAL.

A special meeting of the Memorial Hospital Staff Association was held in the Out Patient Building, October 19, 1920, at 8:45 p. m. The President, Dr. J. A. Remington, was in the chair.

The question of hospital standardization was presented by the President of the Board of Trustees, Mr. Charles O. Read.

The staff voted to return to the system of monthly meetings which were in vogue up to the time of the war. A committee was appointed to carry out the suggestions voiced at the meeting.

J. F. KENNEY, M. D., *Secretary.*

MISCELLANEOUS

PRINCIPAL CAUSES OF DEATH.

CENSUS BUREAU'S SUMMARY OF MORTALITY STATISTICS FOR 1918.

Washington, D. C., February 2, 1920.—The Census Bureau's annual compilation of mortality statistics for the death registration area in continental United States, which will be issued

shortly, shows 1,471,367 deaths as having occurred in 1918, representing a rate of 18.0 per 1,000 population, the highest rate on record in the Census Bureau—due to the influenza pandemic.

INFLUENZA AND PNEUMONIA (ALL FORMS).

Of the total deaths 477,467, or over 32 per cent., were due to influenza and pneumonia (all forms), 380,996 having occurred in the last four months of the year during the influenza pandemic. The rate for influenza and pneumonia (all forms) is 583.2 per 100,000. Influenza caused 244,681 deaths and pneumonia (all forms) 232,786, showing rates of 298.9 and 284.3 per 100,000, respectively, these being the highest rates which have ever appeared for these causes. The rate in 1917 for influenza was 17.2 and for pneumonia (all forms) was 149.8. In fact the difference (416.2 per 100,000 population) between the 1917 and 1918 rates corresponds with the excess mortality which occurred in the last four months of the year from the influenza pandemic.

The next most important causes of death were organic diseases of the heart, tuberculosis (all forms), acute nephritis and Bright's disease, and cancer, which together were responsible for 391,391 deaths, or nearly 27 per cent. of the total number.

The death registration area in 1918 comprised 30 states, the District of Columbia, and 27 registration cities in nonregistration states, with a total estimated population of 81,868,104, or 77.8 per cent. of the estimated population of the United States. The Territory of Hawaii is now a part of the registration area, but the figures given in this summary relate only to continental United States.

The deaths from organic diseases of the heart numbered 124,668, or 152.3 per 100,000 population. The death rate from this cause shows a slight decrease as compared with 1917, when it was 153.2 per 100,000. There have been fluctuations from year to year, but in general there has been a marked increase since 1900, the earliest year for which annual mortality statistics were published, when the rate for organic diseases of the heart was 111.2 per 100,000 population.

Tuberculosis in its various forms caused 122,040 deaths, of which 108,365 were due to tuberculosis of the lungs. The death rate from all

forms of tuberculosis was 149.1 per 100,000, and from tuberculosis of the lungs, 132.4. The rate from tuberculosis of all forms declined continuously from 200.7 per 100,000 in 1904 to 141.6 in 1916, the decrease amounting to nearly 30 per cent.; but for 1917 and 1918 increases are shown, the 1918 rate being somewhat higher than the rate for 1917, when it was 146.4. Until 1912 more deaths were due to tuberculosis than to any other single cause, but in that year and during the period 1914-1918 the mortality from tuberculosis was less than that from heart diseases.

Bright's disease and acute nephritis caused 79,343 deaths, or 96.9 per 100,000. This is a noticeable decrease as compared with 1917 when the rate was 107.4 per 100,000.

Cancer and other malignant tumors were responsible for 65,340 deaths, of which number 24,783, or nearly 38 per cent., resulted from cancer of the stomach and liver. The rate (79.8) is a decrease from 1917, when it was 81.6. With the exceptions of the years 1906, 1907, 1911, 1917, and 1918, there has been a continuous increase in the death rates from these diseases.

Apoplexy was the cause of 64,904 deaths, or 79.3 per 100,000. This rate, too, declined, having been for 1917, 82.9.

Diarrhea and enteritis caused 59,109 deaths, or 72.2 per 100,000, a decrease from the rate (79.0) for 1917. More than four-fifths of the total deaths charged to these causes in 1918 were of infants under two years of age.

Arterial diseases of various kinds—atheroma, aneurism, etc.—resulted in 19,027 deaths, or 23.2 per 100,000, which rate is somewhat less than that (25.3) for 1917.

Deaths from diabetes numbered 12,927, or 15.8 per 100,000. The rate from this disease increased almost continuously from 9.7 in 1900 to 17.0 in 1916, but since 1916 a slight decrease for each year is apparent. The rate for 1917 was 16.9.

Bronchitis caused 12,783 deaths, or 15.6 per 100,000. This rate is lower than that for any preceding year. The proportional decline from 1900, for which year the bronchitis rate was 45.7, to 1918, amounted to 66 per cent.

The rate for diphtheria is 13.8, representing 11,280 deaths. As compared with 1917, when the rate was 16.5, there is a perceptible decrease.

TYPHOID FEVER.

Typhoid fever resulted in 10,210 deaths, or 12.5 per 100,000. The mortality rate from this cause has shown a remarkable reduction since 1900, when it was 35.9, the proportional decrease amounting to 65 per cent. This highly gratifying decline demonstrates in a striking manner the efficacy of improved sanitation and of the modern method of prevention—the use of the antityphoid vaccine.

WHOOPING COUGH AND MEASLES.

Whooping cough and measles together were responsible for 22,534 deaths of adults and children, or 27.6 per 100,000. The rates for these diseases were, respectively, 16.8 and 10.8 as compared with 10.4 and 14.3 for 1917.

EXTERNAL CAUSES.

Deaths due to external causes of all kinds—accidental, suicidal, and homicidal—numbered 82,349 in 1918, corresponding to a rate of 100.6 per 100,000 population. This is a noticeable decrease, the rate for 1917 being 108.8. In fact, except for automobile and machinery accidents and injuries, all the external causes showed a general decrease in 1918.

The greatest number of deaths charged to any one accidental cause—10,330, or 12.6 per 100,000—is shown for falls.

Next to falls, the greatest number of accidental deaths—8,610, or 10.5 per 100,000—resulted from railroad accidents and injuries.

Deaths from automobile accidents and injuries in 1918 totaled 7,525, or 9.2 per 100,000 population. This rate has risen rapidly from year to year, which strongly suggests the need for better traffic regulations and better enforcement of those we now have.

Burns—excluding those received in conflagrations—were responsible for 6,638 deaths, or 8.1 per 100,000.

Accidental drowning caused 5,633 deaths, or 6.9 per 100,000. This rate is considerably less than that for any preceding year since 1910.

Deaths due to accidental asphyxiation (except in conflagrations) numbered 3,371, or 4.2 per 100,000. This rate is slightly less than that, 4.5,

for the previous year, but is somewhat higher than the rate for any year during the preceding ten-year period.

Mine accidents and injuries resulted in 2,497 deaths, or 3.1 per 100,000.

Machinery accidents caused 2,371 deaths, or 2.9 per 100,000, a rate greater than that for any year covered by the Bureau's mortality records.

Deaths resulting from street-car accidents numbered 2,366, corresponding to a rate of 2.9 per 100,000.

Deaths due to injuries by vehicles other than railroad cars, street cars, and automobiles numbered 2,337, or 2.7 per 100,000.

The number of suicides reported for 1918 was 9,937, or 12.1 per 100,000, the rate being the lowest shown for any year since 1903.

Other deaths due to external causes total 20,834, or 25.4 per 100,000.

COMPULSORY HEALTH INSURANCE.

CHAMBER OF COMMERCE OF THE STATE OF NEW YORK.

At the regular monthly meeting of the Chamber of Commerce of the State of New York, held April 1, 1920, the following preamble and resolution, presented by its Committee on Insurance, were unanimously adopted:

To the Chamber of Commerce:

COMPULSORY HEALTH INSURANCE

BILL OPPOSED.

Whereas, On February 6, 1919, your Committee on Insurance reviewed the earlier action of the Chamber with regard to certain bills in Albany, providing, in varying forms, for compulsory health insurance, and then restated its belief that a commission should be created to study the whole matter before any legislation of this character was undertaken by this State; and

Whereas, The committee's recommendations at the time were approved by the Chamber, but so far as your committee is informed no commission has ever been created, no comprehensive study of the subject has been made on behalf of the State; and

Whereas, Senator Davenport has introduced in the Upper House of the Legislature, Introductory No. 986, a Bill "To conserve the human

resources of the State by establishing for employees a system of mutual health insurance funds, constituting Chapter 171 of the Consolidated Laws; and

Whereas, Said bill if enacted will make health insurance after the first of April, 1921, compulsory upon every employee in the State, with minor exceptions, without physical examination; and

Whereas, Further study of the whole subject has convinced your committee that compulsory health insurance attacks the problem from the wrong point of view, and that it is economically unsound and thoroughly unwise. In support of which conclusion your committee submit the following general observations:

1. It is opposed to sound public policy in a democracy, in fostering objectionable class distinctions and a dangerous tendency toward a stratification of industrial society.

2. It is opposed to public policy in encouraging public extravagance, largely through the employment of unnecessary official and other functionaries.

3. It is opposed to public policy by giving encouragement to socialistic tendencies, and the further and dangerous enlargement of the sphere of the State.

4. It is opposed to public policy in favoring a further encroachment upon private rights and privileges, including the most personal concerns of the individual, and the supervision, control and direction of the person in matters of health and welfare.

5. It is a danger to democracy, in that the promises made are impossible of fulfillment, and on this ground will ultimately create an unwholesome industrial unrest.

6. It is a delusion in that the poorest poor, who are most urgently in need of sympathetic medical and financial support and assistance are largely if not wholly outside the sphere of social insurance activities of any and every kind.

7. Such demand for compulsory health insurance as exists has been artificially created by a skillful propaganda.

8. It is opposed by conservative leaders of organized labor in this country and abroad.

9. It is opposed by business interests as visionary and dangerous and unnecessary class legislation.

10. It is at best a palliative, and does not reach the seat of the difficulty.

11. It does not promote the health of the individual, but rather fosters a tendency toward malingering and an undue prolongation of minor ailments for the purpose of wrongful gain.

12. Experience in other countries shows that medical treatment under its rule results in a standardized method of mediocre medical practice—the doctor who gives his whole time to the service reduces his profession to a mere trade; the doctor who gives only part of his time to the practice is bound to give it indifferent attention.

13. Experience abroad has also shown that medical practice under this system tends strongly toward a system of public medicine, opinion being divided as to whether under such a system private practice should be allowed at all, or whether the system should be universal; in other words, whether the doctor should become a State employee, leaving private practice and the work of the specialists to the few who are unwilling to submit themselves to State control.

14. All the estimates in England have been more or less at variance with actual experience. The State contribution has been very much greater than had been assumed would be necessary at the outset.

15. English experience shows the original assumptions as to benefits were erroneous, and a continuous agitation exists in favor of an increase in benefits. This applies to the work of those who have the work of administration, and particularly to the fees of the doctors as well as to the benefits guaranteed.

16. We are informed that in Great Britain it is absolutely impossible to fulfill the promises held out by Mr. Lloyd George in 1911. Some facts from the British experience are informing—

(a) Beginning with the non-contributory old-age pensions as a gift to the poor, the British Nation assumed a responsibility of possibly £30,000,000 per annum.

(b) This during the war was followed by out-of-work donations costing not far from £50,000,000 per annum and a bread subsidy estimated at £60,000,000 per annum and in addition, allowances on account of coal prices equivalent to a subsidy of £30,000,000 per annum.

(c) On a basis of the best data obtainable, the British Government's grants and gratuities and subsidies of all kinds under national health insurance cannot be less than £30,000,000 per annum.

(d) or a total of probably not far from £200,000,000 per annum in grants, gratuities and subsidies.

These do not include the Poor Law expenditures, war pensions, etc.

17. Experience in Germany has been similar to that in Great Britain.

18. Compulsory health insurance is an elaborate bureaucratic scheme which controls wage-earners' lives and wage-earners' incomes. The hope held out that the institution to be created will be thoroughly democratic and, apart from the overhead charges, self-sustaining, never has been and probably never will be realized. Control of essentials soon passes into the hands of the State authorities, with a corresponding increase in the power of bureaucracy.

19. Generally speaking we have made greater progress in sanitation, in the reduction of the death rate, in the development of voluntary health promoting agencies and all that goes with it, than any other country in the world; and

Whereas, In addition to these general observations, your committee offers the following observations with regard to this particular bill which we believe to be un-American, economically unsound, socially wrong and financially unwise:

1. The cost of insurance proper is to be divided substantially equally between the employers and the employees. Someone has estimated the probable annual charge at \$250,000,000. It is further estimated that the fixed overhead charges—one-half of which must be paid by the employees, will amount to \$20,000,000 a year; and although it is difficult to arrive at any estimate of what the State must pay, over and above the payments from the various funds created, the forecast of from \$8,000,000 to \$9,000,000 per annum is the best your committee has been able to arrive at. This as the plant developed probably would ultimately prove to be underestimated.

2. The head of the Health Insurance Bureau which is to be created by the Industrial Commission is given what amounts to autocratic powers over the services of physicians to be employed.

3. There seems to be no limit to the expenses which may be incurred.

4. Amongst the amounts that may be charged to "Management Expenses" of funds is an apparently unlimited authorization for expenses in investigating disease prevention, and instruction in hygiene—excellent undertakings if properly pursued and under proper limitation.

5. Under the general head of "managing and conducting" the business, there is apparently no limit whatever fixed as to the expenses which may be incurred; but the various funds must be planned so as to cover whatever may be incurred.

6. The insurance of every employee, with the exceptions named, without regard to physical examination or condition, would probably result after a time in a practice under which a person in indifferent health could not get a job anywhere.

7. Provision is made to insure people who are not residents of the State, the inherent difficulties of which proceeding do not seem to have occurred to the authors of the bill.

8. Appropriations of the New York Legislature for all purposes have increased from \$43,000,000 in 1910 to \$117,000,000 this year. Assuming that the State would not have to pay anything beyond the estimated \$8,000,000 or \$9,000,000 overhead charges, there is nothing in the German or English experience to show any reduction in their poor law expenditures, and there is no reason to assume that such a measure here would produce a different experience.

9. A proper increase in the activities of the Department of Public Health, better instruction in sanitation and hygiene in the public schools, almost any program that does not invade private rights and impair self-respect, would be welcomed by this and every public-spirited body.

Resolved, That the Chamber of Commerce of the State of New York is opposed to the passage of what is known as the Davenport Bill, Introductory No. 986, and urges upon the

members of the Legislature the duty of opposing its enactment into law.

Respectfully submitted,

DARWIN P. KINGSLEY, *Chairman*

WILLIAM J. TULLY,

JOHN J. PULLEYN,

ISAAC B. JOHNSON,

WILSON S. KINNEAR,

ALBERT B. ASHFORTH,

Of the Committee on Insurance.

Attest:

CHARLES T. GWYNNE,

Secretary.

ALFRED E. MARLING,

President.

New York, April 2, 1920.

NOTICE

THE JOURNAL and the Co-operative Medical Advertising Bureau, 535 North Dearborn street, Chicago, maintain a Service Department to answer inquiries from you about pharmaceuticals, surgical instruments, and other manufactured products, such as soaps, clothing, automobiles, etc., which you may need in your home, office, sanitarium or hospital.

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PRIZE FOR THE BEST PAPER IN OUR SOCIETIES.

A Fellow of the Rhode Island Medical Society, who has always had the best interests of the profession at heart, has announced that he will give a prize of One Hundred Dollars to the reader of the best paper read before the Rhode Island Medical Society or the Providence Medical Association during the coming year. The officers of these Societies are to be the judges of the merits of the paper. The paper may be written upon any subject of medical interest and must be original.